Misogyny and Misandry: Reasons and Mitigating Strategies in the Sample of Antenatal Patients in Tertiary Health Facilities in Owerri Municipal Imo State, Nigeria

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Abstract

This study investigated reasons and mitigating strategies for misogyny and misandry in a sample of antenatal patients in tertiary health facilities in Owerri Municipal, Imo State, Nigeria. A descriptive cross-sectional survey design was employed to carry out the study. The population consisted of antenatal patients accessing health services at Federal Medical Centre Owerri within the period of the administration of the questionnaire which lasted for two weeks. The sample size was 350 patients drawn randomly. A structured 25-item misogyny and Misandry: Reasons and Mitigating strategies Questionnaire (MMRMSQ) served as the instrument for data collection. Means and standard deviations were used to answer the research questions. Results showed that superiority complex shown by male health care givers, sexual abuse, differentiated treatment, unfaithfulness in relationship, cultural norms and religious beliefs are some of the reasons for misandry while aggression, neglect from female antenatal care givers, abusive treatment both in words and action are some of the reasons for misogyny. Health education, creating awareness, positive change in behavior and faithfulness in relationship were some of the identified mitigation strategies for misogyny and misandry. Findings suggested planning and implementing gender bias-free antenatal services by antenatal service providers and hospital management to avoid differentiated treatment; promote acceptance of gender diversity in the medical and paramedical profession and health education of antenatal patients by health educators on the consequences of misogyny and misandry on pregnancy outcome, and importance of good relationship skills in accessing antenatal care services. The aim of this education is to promote patronage of antenatal services among pregnant women, eventual improved delivery as well as maternal and child health.

***Keywords**: Misogyny, Misandry, antenatal, Mitigation, Strategy, Facility*

Introduction

Health is fundamental to a good quality of life and can be promoted through health services. One of such health services is antenatal care (ANC). Antenatal care is globally advocated as the cornerstone for reducing infant mortality and improving maternal health. This goal of antenatal care may be truncated by factors such as gender-related issues which include: gender inequality, gender discrimination, stereotype and sexism. Women and girls face unimaginable challenges in almost every part of the world. For instance, Australian females as reported by Australian Institute of Health and Welfare (2019) experience more violence as well as different health outcomes than males. In Nigeria, Imo state inclusive, Fagbamigbe and Idemudia (2015) revealed that gender bias and inequality exist. These gender issues cut across all spheres of life, be it family, religion, societal, ethnic, occupation, just to mention a few. For years, there have been gender-related conflicts, males against females and vice versa. This conflict most at times results to hatred for a particular gender especially the opposite sex. This hatred is termed misogyny and misandry. Misogyny according to Smykowski (2018) is the dislike of, contempt for, or ingrained prejudice against women. Porter (2019) defined misandry as hatred of, contempt for, or prejudice against men. Misogyny as revealed by Eaton (2018) has centuries of research, evidence, statistics, law and legislation, oppression, death and suffering behind

it while misandry is harder to pinpoint because of the belief that men cannot be harmed, abused or oppressed by women.

Misogyny and misandry can take the form of violence, social exclusion, sex discrimination, hostility, gynocentrism, belittling and sexual objectification. Those that have hatred for males are called misandrist while those that have hatred for females are called misogynists. Both misandrist and misogynist could be of the same gender, that is, a female can be a misogynist and a male can be a misandrist. This is because when misogyny and misandry is internalized as revealed by Eaton (2018), the individual begins to enact sexist actions and attitudes toward themselves and people of their own sex. For instance, women who experience internalized misogyny may express it through minimizing the value of women, mistrusting women and believe gender bias in favour of men. Berit (2015) reported that misogyny or misandry is typically an unconscious hatred people form early in life for either opposite sex or same sex.

Misogynists and misandrists manifest this hatred while dealing with people in all spheres of life. Meredeth (2015) reported that sexism, of which misogyny and misandry belong, exists in employment, education and in health care. In another study, Zhuge, Kaufman, Simeon, Chen and Velazyuez (2011) revealed that female patients face discrimination through denial of treatment, especially, when it is related to pains associated with child birth. In the same vein, Wojciechowski (2016) reported that male nurses are often subjected to stereotypic treatment as a result of being in a largely female dominated field. This stereotype may exist in some patients not feeling comfortable with male nurses.

This stereotype may hinder male nurses and other male medical professionals from providing medical care to patients including antenatal care. Antenatal is the care provided by skilled health-care professionals to pregnant women in order to ensure the best health condition for both the mother and baby during pregnancy. According to Abalos, Chamillard, Diaz, Tuncalp and Tuncalp (2015), antenatal care (ANC) is the care provided by health practitioners (or others) to all pregnant women to ensure the best health condition for the women and their foetuses, during pregnancy. Antenatal care is the care a pregnant woman receives during pregnancy through a series of consultations with trained health care workers, such as: midwives, nurses, and sometimes a doctor who specializes in pregnancy and child birth. From the foregoing, the aim of antenatal care is to reduce the risk of stillbirths and pregnancy-related complications and give women positive pregnancy experiences. Antenatal care reduces maternal and perinatal morbidity and mortality directly through detection and treatment of pregnancy-related complications and indirectly through the identification of women with increased risk of developing complication during labour and delivery, and referring such patients to the appropriate level of medical care.

The aim of antenatal care which according to Ngxongo (2018) include: promotion and maintenance of the physical and social health of the mother and the baby, detection and management of complications during pregnancy, development of birth preparedness and complication readiness plan, and preparation of women for normal puerperium. All the above cannot be fully achieved with the existence of misogyny and misandry among patients accessing antenatal care services. This is because a pregnant woman who is a misogynist will not accept being attended to by a female medical professional and the misandrist will not accept any antenatal care service from male medical professional. The problem with this hatred is that if the healthcare service providers in a particular health facility (which may be the only accessible facility to a patient) are females only, a misogynist antenatal patient may not seek antenatal care from that health facility and this may result in negative pregnancy outcome. Antenatal care is usually provided in health facilities. A health facility is any location where healthcare is provided. They include hospitals, clinics, outpatient care centres, and specialized centres such as birthing centres and psychiatric care centres. These health facilities are grouped into three levels, namely; primary health facility, secondary health facility, and tertiary health facility. Tertiary health facilities according to Fadare and Godman (2019) comprise mainly Federal Medical Centres and University Teaching Hospitals and they are the best equipped in terms of personnel and equipment, hence the choice of a tertiary facility for this study.

All health facilities are established to provide health care services, but when people, especially antenatal patients deny themselves of these health services due to misogyny and misandry, it may have detrimental effects on their health. The effects of misogyny and misandry among pregnant women who seek antenatal care as reported by Kahn (2018), include: safe hatred (this

manifests in not seeking antenatal care early or at all when the gender they hate is the provider); self-harming behaviours (such as not taking medication as prescribed by a medical professional or failure to keep to antenatal appointments); and aggressive behaviours such as verbal hostility, nonverbal intimidation, and passive aggression which may manifest in indirect way of expressing displeasure or anger. Smykowski (2018) affirms that misogyny and misandry affect both medical professionals and patients through differentiated treatment and poorer health services to the gender hated. Misogyny and misandry among antenatal care patients increase maternal morbidity and mortality (Souza, et.al. 2013). To reduce maternal morbidity and mortality, the contributory factors misogyny and misandry need to be addressed by the government, educationists, and those in the health sector.

Many factors contribute to misogyny and misandry. These factors according to Fagbamigbe and ldemudia (2015) and Le Tourneau (2018) include: unfairness of antenatal service providers in discharging their duties, sexism, a combination of cultural preferences, and government decrees among others. Some antenatal patients may not want male health care providers to attend to them due to cultural norms, religious belief, certain human factors, such as the belief that men are bad, attitude and behaviour common with a particular gender (of both patients and antenatal care providers). Such behaviours as observed by Dairo and Owoyokun (2010), and Ajayi and Osakinde (2013) include: failure to respect the privacy, confidentiality and traditional beliefs of health care seekers. Some pregnant women do not seek antenatal care at all because as revealed by Fagbamigbe and Idumudia, the providers are not of the same gender. Therefore, gender difference may be one of the reasons for misogyny and misandry. Porter (2019) revealed some of the reasons for misogyny to include the way women are portrayed in media, culture and gender norms.

Ignorance and misinterpretation according to Rivers (2018) are the main reasons for misogyny and misandry. Trauma involving a trusted male or female figure; an abusive or negligent mother, sibling or teacher; neglect; sexual abuse; lack of fair treatment; cheating; and unfaithfulness in a relationship as revealed by Berit (2015) are some of the reasons for misogyny and misandry. Smykowski (2018) revealed that feeling of insecurity, preferential treatment and poor value on women can predispose pregnant women to misandry in relation to seeking antenatal care. In line with the above report, Kahn (2018) observed that misandrist women tend to organize their lives with as little contact to men as much as possible. They may do this by avoiding men as friends, office mates, employers, employees, and this may be one of the reasons some women choose to be a single parent to getting married. Cultural norms and religious ideologies contribute to misogyny and misandry among patients of antenatal care services. This statement is supported by the findings of Hakim (2017) that religious belief is one of the reasons for misogyny and misandry among antenatal patients. In the same vein, Fitzsimons (2019) also revealed that traditional masculinity ideology which is promoted by religion is linked to homophobia misogyny. This is because it results in gender role strain and role conflict. Therefore, the unconscious hatred for women could be said to be nurtured and legitimized by religion. On the contrary, the findings of Budu, Abalo and Peprah (2019) disproved the assertion that religion promotes misogyny and misandry. There are other reasons that may contribute to a pregnant woman's choice of choosing either a male or female health care provider during antenatal care visits. The reasons for misogyny among antenatal patients as revealed by Hakim; and Budu et al, include: preferred interest, a previous bad experience with a female nurse, and to avoid plain embarrassment, not being polite or courteous.

These reasons for misogyny and misandry can be mitigated through certain strategies. Mitigation refers to measures taken to reduce or remove identified impacts. These measures could be termed strategies. Strategy is a detailed plan of action or set of plans to achieve a long term or overall aim. Mitigation strategy aims to avoid, minimize, rectify, eliminate, and or compensate for an identified impact. Antenatal care is important in screening, diagnosing, managing and controlling the risk factors that might adversely affect pregnant women and or the pregnancy outcome. Therefore, when a pregnant woman fails to access antenatal care, there may be consequences; these consequences are the identified impacts. Health education and awareness creation on the consequences of this abnormal behaviour on the mother and the unborn child were reported by Kahn (2018) as a mitigating strategy for misogyny and misandry among pregnant females. Education as revealed by Budu et al. (2019) is a mitigating strategy for misogyny and misandry among antenatal patients. This is because education usually brings a positive change in behaviour. Psychological counseling for victims of sexual abuse before or during the pregnancy can also help in mitigating

these menaces. Creating gender bias awareness may play a role in reducing misogyny and misandry, this is because gender bias awareness will help to promote acceptance of gender diversity in medical and paramedical professions. The major reasons for misogyny and misandry, such as sexual discrimination, denigration of men or women, violence and sexual objectification need to be addressed by the government and the society at large through various mitigating strategies. Harvard School of Education (2018) revealed that misogyny and misandry can be reduced among antenatal care patients through clearly defining sexual harassment and degradation, upholding cultures that are not anti-health, and having a self-worth.

Mitigation of misogyny and misandry is crucial since they pose hindrance to the attainment of the aim of antenatal care services which is to reduce and as much as possible prevent maternal and infant morbidity and mortality. This is because they are capable of preventing antenatal patients from accessing affordable antenatal care services due to hatred for the provider's gender. The findings of this study will be of immense benefit to the government, health educators, health counsellors, and antenatal care providers and patients. It will help the government to formulate new policies that will address reasons for misogyny and misandry. The findings will help antenatal care providers plan and implement fair, gender-unbias care services to patients and to maintain good working relationship with their patients. It is hoped that the findings would provide vital and useful information to both health educators and counsellors that will help them in educating and counselling victims of misogyny and misandry. Based on the foregoing, the study aimed to investigate specifically the reasons for misogyny and misandry and their mitigation strategies in a sample of antenatal patients in Owerri Municipal, Imo state, Nigeria. The choice of Owerri Municipal is because it is a metropolis with varied population that cut across age, religion, culture, states and countries.

Method

A descriptive cross-sectional survey design was adopted to achieve the aim of the study. The population of the study comprised antenatal patients in tertiary health facilities in Owerri Municipal, Imo State. Since the only tertiary health facility in Owerri Municipal, Imo State is the Federal Medical Centre (FMC) Owerri, it was drawn for the study. The sample size was 378 antenatal patients drawn randomly using simple random selection of balloting without replacement. A structured instrument called Misogyny and Misandry Reasons and Mitigation Strategies Questionnaire (MMRMSQ) with a four-point liker type scale with response options of Strongly Agreed, Agreed, Disagreed and Strongly Disagreed was used for data collection. The points assigned to the reading scale were 4, 3, 2 and 1 respectively. The criterion mean was placed at 2.50 since this is the lowest limit for Agreed. Therefore, any item with mean of 2.50 and above was significant as either a reason or mitigating strategy respectively, while any mean below 2.50 was not significant. The instrument comprised two sections, A and B. Section A contained 15 items on the reasons of misogyny and misandry while section B contained 10 items on the mitigating strategies for misogyny and misandry. The instrument was validated by three lecturers, two from the Department of Health Education and one from the Department of Measurement and Evaluation in Alvan Ikoku Federal College of Education, Owerri. To establish the internal consistency of the instrument, Crombach Coefficient Alpha was adopted and coefficients of 0.84 (alpha 0.84) was obtained on both the reasons and mitigating strategies of misogyny and misandry. To access the respondents, the researchers wrote an introductory letter to the Head of the Department/ Director of the antenatal unit in FMC Owerri on their first visit. The researchers were given three days each for the two weeks of data collection. On the agreed days, the researchers with the aid of the nurses on duty administered the instrument to the respondents. The administered copies of the instrument were retrieved on the spot and this lasted for two weeks. The reason for two weeks was because all the antenatal patients do not have the same date for accessing antenatal healthcare services. Three hundred and seventy-eight copies of the instrument were administered and returned. Therefore, the return rate was 100% although only 350 out of 378 administered instruments were used, due to the fact that, some were either not filled at all or incompletely filled. The data received were analysed with descriptive statistics of means and standard deviations.

Results

Table 1: Means and Standard Deviations of Reasons for Misogyny and Misandry

	Reasons for apathy for male health providers	**Responses**		
S/n	**Items**	**Mean**	±	**SD**
1.	They may have been sexually abused by males in the past.	3.0	±	1.0
2.	They do not want males to see their nakedness.	3.2	±	1.2
3.	Religious beliefs	3.3	±	1.4
4.	The belief that men are bad	2.9	±	0.9
5.	Their past experience of unfaithful relationship with a male figure	3.0	±	1.0
6.	Insecurity while dealing with males	3.2	±	1.2
7.	Superiority complex shown by male providers	3.7	±	2.0
8.	They are simply shy	3.2	±	1.2
9.	Cultural norms	3.4	±	1.6
10.	Differential treatment received from male antenatal care providers	3.1	±	1.0
	Reasons for apathy for female health providers			
11.	They are usually aggressive	3.5	±	1.8
12	Past experience of an abusive female figure	3.2	±	1.2
13.	They feel neglected by female providers	3.1	±	1.0
14.	Some female providers are fond of making derogatory statements about them	3.0	±	1.0
15.	Inability of female providers in keeping secret	3.2	±	1.2

Criterion Mean at 2.50

Table 1 shows that all the items scored above a criterion mean of 2.50 and therefore are all significant reasons for misogyny and misandry. This shows that reasons for apathy for male healthcare providers in their descending order of significance are superiority complex, cultural norms, religious beliefs, being shy as well as unwillingness to males seeing their nakedness. Other reasons include differential treatment received from male antenatal care providers, sexual abuse and belief that men are bad. The item with the highest mean score of 3.7 was superiority complex, followed by cultural norms with the mean score of 3.4 while the item with the lowest mean score of 2.9 was the belief that men are bad. On the other hand, the reasons for apathy for female health care providers are aggression, abuse as well as the inability of female providers in keeping secret; neglect and making derogatory statements about antenatal patients were also significant reasons for misogyny. All the items had mean score above the criterion mean of 2.50. This implies that antenatal patients indicated all the items on the table as reasons for misandry and misogyny.

Table 2: Means and Standard Deviations on Mitigating Strategies for Misogyny and Misandry

	Mitigating strategies	**Responses**		
S/n		**Mean**	±	**SD**
16	Health education	3.0	±	1.0
17	Creating awareness on the consequences of misogyny and misandry on pregnancy outcome	3.2	±	1.2
18	Gender-bias awareness	3.3	±	1.2
19	Formation of antenatal patients and providers forum	3.4	±	1.6
20	Enlightenment programme on misogyny and misandry	3.3	±	1.2

21	A positive change in behaviour of antenatal care service providers.	3.8	±	2.0
22	Giving males and females equal treatment	3.2	±	1.2
23	Protecting the girl and boy child from sexual abuse	3.0	±	1.0
24	Being faithful in relationship.	3.1	±	1.0
25	Creating awareness on positive relationship skills.	3.4	±	1.6

×Criterion Mean at 2.50

Table 2 shows that all the items scored a criterion mean above 2.50 and therefore are all significant mitigation strategies. The table revealed that a positive change in behaviour, formation of antenatal patients and providers' forum as well as creating awareness on positive relationship skills, gender-bias awareness and enlightenment programme on misogyny and misandry with mean scores of 3.8, 3.4, 3.3 and 3.2 respectively are some of the mitigating strategies for misogyny and misandry. Other mitigating strategies include; being faithful in relationship, protecting the girl and boy child from sexual abuse and health education. Since all the items had values above 2.50, it implies that antenatal patients indicated all the item in the table as significant mitigating strategies for misogyny and misandry.

Discussions

This study generated data on reasons and mitigating strategies for misogyny and misandry in a sample of antenatal patients in tertiary health facilities (Federal Medical Centre) in Owerri Municipal, Imo State, Nigeria. Findings in table 1 revealed that antenatal patients indicated that superiority complex shown by male providers, cultural norms, religious beliefs, being shy, and unwillingness for males to see their nakedness, insecurity while dealing with males, differentiated treatment, sexual abuse, unfaithfulness in relationship and the belief that men are bad are some of the significant reasons for misandry. The findings were expected and not surprising because superiority complex shown by males toward females is evident in almost all spheres of life. The findings were similar to the findings of Fitzsimons (2019) which revealed that traditional masculinity ideologies were linked to misandry. The findings also corroborated with the findings of Smykowski (2018) which revealed differentiated treatment, and the findings of LeTourneau (2019) which revealed sexism and a combination of cultural preferences of males over females as some of the reasons for misandry. The findings on religious beliefs and cultural norms as reasons for misandry was in affirmation with the findings of Fitzsimons that traditional masculinity ideology which stem from cultural norms and religious ideologies contribute to misandry but is in contrast with the findings of Budu et al. (2019) which disproved the assertion that religion promotes misogyny and misandry. The findings of Wojciechowski (2016) that male nurses are often subjected to stereotype treatment which may manifest in some patients not being comfortable with male providers supports these finding that some patients do not want male providers to see their nakedness.

Findings in Table 1 also revealed that aggression, past experience of an abusive female figure, inability of female providers to keep secret, neglect and making of derogatory statements by female antenatal service providers are some of the reasons for misogyny. The findings were consistent with the findings of Bubu et al. (2019) which revealed that female antenatal providers are usually not polite and courteous while discharging their duties. When these behaviours are negative, it scares antenatal patients away from such antenatal service providers. This finding supports the assumption that most female antenatal service providers are aggressive and throw tantrums when discharging their duties. The reason for these behaviours among female antenatal care providers may be attributed to inferiority complex or being seen as secondary in health care delivery system by their male counterparts. The finding on past experience with an abusive female figure as one of the causes of misogyny corroborates the finding of Berit (2015) that trauma involving a trusted female figure, having an abusive or negligent mother can cause apathy for female antenatal service providers. The finding may be attributed to some of these female antenatal care providers being authoritative while discharging their duties.

Findings in Table 2 showed that a positive change in behaviour of antenatal service providers is a strong significant factor in mitigating misogyny and misandry. It is widely believed that behavioural change plays a significant role in health promotion and positive change in behaviour among those seeking antenatal care services and providers of antenatal care services will promote and maternal health. These findings were similar to the finding of Kahn (2018) who reported that awareness creation on consequences of abnormal behaviours of antenatal service providers is one of the ways of preventing or mitigating misogyny and misandry. This is because awareness usually brings a positive change in behaviour. When antenatal service providers become aware of the impact and consequences of their negative behaviours on the patients, they tend to refrain from such behaviours. The findings also revealed that awareness on gender bias, positive relationship skills as well as gender bias are among the strategies for mitigating misogyny and misandry. The finding agreed with the findings of Budu et al. (2019) that public awareness promotes acceptance of gender diversity in nursing profession.

Findings in Table 2 further revealed that gender equality plays a role in mitigating misogyny and misandry. People tend to function effectively and efficiently in a system where they are treated equally and fairly but, in an environment or system where inequality is the order of the day, even the best in such a system will not be appreciated because the people were not given a sense of belonging. When antenatal patients observe that they are not treated equally by either male or female antenatal service providers, they will develop apathy for such a gender and this will result in misogyny or misandry. But when treated equally and fairly, misogyny and misandry will be drastically reduced. This finding is congruent with Wojciechowski (2016) who revealed that gender equality in health care service provision curbs stereotypical treatment which in turn mitigates misogyny and misandry indirectly. Faithfulness in a relationship is also revealed by the findings as a mitigating strategy for misogyny and misandry. One of the best ways of bringing solution to a problem is by addressing its root cause. For instance, Berit (2015) reported that unfaithfulness in relationships is one of the reasons for misogyny and misandry. This finding supports that faithfulness in relationships is a mitigating strategy for misogyny and misandry. The table further revealed health education as a mitigating strategy for misogyny and misandry. Health education is one aspect of education that aims at positive change in health behaviours. When antenatal patients change their behaviour of apathy towards antenatal care providers, they will begin to reap the dividends of antenatal services which include improved maternal and child health. The findings are consistent with the findings of Budu et al. (2019) that education is a mitigating strategy for misogyny and misandry.

Conclusion

Based on the major findings of the study, it was concluded that several reasons led to misogyny and misandry among antenatal patients. Some of these reasons are behavioural, such as: aggression, neglect, unfaithfulness in relationships and abuse, be it verbal or otherwise. Other reasons were cultural, religious and superiority complex. Where and when these reasons for apathy abound, the aim of antenatal services may be defeated especially when the gender the antenatal patient has apathy for is the only antenatal service provider in such an antenatal service center. Health education, awareness creation, faithfulness in relationship and security from abuse are also some of the mitigating strategies for misogyny and misandry among antenatal patients

Recommendations

1. Planning and implementing gender bias-free antenatal services by antenatal service providers and hospital management to avoid differentiated treatment promote acceptance of gender diversity in the medical and paramedical profession.
2. Health education of antenatal patients by health educators on the consequences of misogyny and misandry on pregnancy outcome and, importance of good relationship skills in accessing antenatal care services. The aim of this education is to promote patronage of antenatal services among pregnant women.
3. Developing counselling programs and, providing affordable and acceptable counselling services for victims of abuse by health counsellors to improve their psychological health.

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